MAY 17, 1996

UPDATE 96-14

TO:
Case Management Providers
County/Tribal Aging Units
County Departments of:
- Community Programs
- Human Services
- Social Services

Independent Living Centers
Local Health Departments

WISCONSIN MEDICAID
UPDATE

New Case Management Target Populations
Effective for Dates of Service on and after July 29, 1995

Biennial budget adds four new target populations

Wisconsin Act 27, Laws of 1995, the biennial budget, includes provisions to serve four new target populations for Wisconsin Medicaid case management services.

Wisconsin Medicaid covers the following new target populations for case management:

1. families with children at risk of physical, mental or emotional dysfunction
2. children enrolled in a Birth to 3 program under HSS 90, Wis. Admin. Code
3. children with asthma
4. individuals infected with tuberculosis (TB)

These new target populations are effective for dates of service on and after July 29, 1995. Providers may bill retroactively if they meet all the requirements in this *Update* and the case management (Part U) handbook.

Target population specific information is included in appendices attached to this *Update*.

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Part U Handbook Appendices Are Attached

What to do if you are interested in providing services to the new target populations

If you are *currently* a Medicaid-certified case management provider

If you are currently a Medicaid-certified case management provider, do the following:

1. Complete Appendix 4 (attached to this *Update)* and return it to EDS. (Disregard this if you already sent in your request.)

2. If you want retroactive reimbursement for services to the new target populations (or were certified after July 29, 1995, and want to be retroactively certified back to July 29, 1995), you must send in Appendix 4 (attached to this *Update)* by June 15, 1996. On the form, write:

   "please assign a retroactive effective date of_____" (not to precede July 29, 1995)

If you are *not* currently a Medicaid-certified case management provider

If you are not currently a Medicaid-certified case management provider, do the following:

1. Ask for a certification packet by writing or calling:

   EDS
   Attn: Provider Maintenance
   6406 Bridge Road
   Madison, WI 53784-0006
   (800) 947-9627 or (608) 221-9883

2. If you want retroactive certification, request a certification packet *immediately* from EDS and return it within 30 days. You *must* request to have your certification backdated to July 29, 1995. Wisconsin Medicaid will *not* backdate case management certification to July 29, 1995, for certification packets initially received at EDS on and after June 15, 1996.

Case management providers who work with TB-infected recipients

The budget created a new target population for recipients with TB, but recipients in existing target populations may get the infection or develop the disease.

All case management agencies need to do all of the following:

- know the specific regulations governing transport of infected individuals
- know good practice protocols when working with TB-infected or TB-diseased individuals
- decide if it's appropriate to transfer the case management responsibility to a different agency when the recipient is receiving treatment for TB
- communicate with the local health department when working with TB-infected individuals

Please contact your local health department if you want additional information about TB.

Local Birth to 3 programs asked to use "03" target population code

The Bureau of Developmental Disabilities Services (Division of Community Services) requests that local Birth to 3 programs use the "03" target population code for *all* Birth to 3 recipients when billing for case management services. Using the "03" code allows statewide tracking of services to this group.

One advantage to using the "03" target population code is that Wisconsin Medicaid covers two assessments and two case plans per year for recipients in this group. Only one assessment and case plan is covered per year (unless the recipient changes county of residence) if recipients are billed using the "01" target population code.

Revised Part U appendices included with this *Update*

Follow the attached filing instructions so you can insert the revised appendices into your case management (Part U) handbook. (If you are not a provider and would like to purchase a complete copy of the case management handbook, contact EDS at (800) 947-9627 or (608) 221-9883.)

The revised appendices are:

- *Appendix 3* - Target Population Codes and HCPCS Procedure Codes
- *Appendix 4* - Target population "Change Request" Form

Case management with HMO enrollees

Beginning July 1, 1996, Wisconsin Medicaid will reimburse case management agencies on a fee for service basis for case management services provided to HMO enrolles. However, because both HMOs and case management agencies have responsibility for coordinating care to recipients, we have developed guidelines to address the roles and responsibilities of each entity. These guidelines will be contained in both the HMO contracts and the case management handbook. A draft of these guidelines is included in this Medicaid Update as Attachment 10.

Training audiotapes available

Audiotapes of the December 5, 1995, case management ETN training are available. New staff as well as staff from newly-certified case management providers will find the training particularly useful. The training covers *all* case management policy and billing procedures effective on the date of the training. When there are informational conflicts between the audiotape and provider publications, the *most recent* provider publication is considered the effective policy.

Audiotapes are available from:

Radio Hall
Attn: Donna
975 Observatory Drive
Madison, WI 53706

When requesting an audiotape, include all of the following:

- a $14.14 check
- the date of the training (December 5, 1995)
- the name of the training (Medicaid Case Management)
- training time (10:00 AM - 12:50 PM)

Attachment 1

Case Management New Target Populations Eligibility Requirements

This attachment describes the new case management target population eligibility requirements and required documentation. The new target populations are: 1) families with children at risk of physical, mental or emotional dysfunction; 2) children enrolled in a Birth to 3 program certified under HSS 90, Wis. Admin. Code; 3) children with asthma; and 4) individuals infected with tuberculosis.

Families with children at-risk of physical, mental or emotional dysfunction

This target population is comprised of five subgroups, which are described in this section. "Child" is defined as an individual under age 21. Case management services for this group are sometimes referred to as *"family case management."*

Families with a child with special health care needs

Children included in this category
A child with a special health care need exhibits biological or environmental characteristics associated with a heightened probability of developing a chronic physical, developmental, behavioral or emotional condition. This special health care need requires health or health-related services of a type or amount beyond that generally required by children.

The following are examples of conditions that cause a child to be considered a child with special health care needs.

- congenital conditions (e.g., cerebral palsy, spina bifida, congenital heart disease)
- acquired illnesses or injuries (e.g., spinal cord injury, intracranial injury)
- behavioral health conditions (e.g., substance abuse, attention deficit disorder)
- chronic health conditions (e.g., seizure disorders, juvenile diabetes)
- physical or sensory disorders (e.g., sensorineural hearing loss)

Required documentation
The record must contain documentation from a physician (for children with emotional disturbances, this may be a licensed psychologist who meets Medicaid certification requirements) that the child's condition meets all of the following:

- is severe enough to restrict the child's growth, physical or emotional development, or ability to engage in usual activities
- has been or is likely to persist for at least 12 months
- is of sufficient complexity to require specialized health care services

Families with a child who is at risk of maltreatment

Required documentation
The county agency responsible for child protective services documents a finding that abuse or neglect has or is likely to occur. The county makes this finding through the use of a structured assessment tool, which assesses all of the following:

- the manner in which the caregiver(s) parent the child
- the child's current level of daily functioning
- the caregiver(s) level of functioning (including mental health functioning)
- the family's functioning, ability to cope with current stressors and the resources available to help the family cope
- the risk of maltreatment to other children in the family
- past allegations of maltreatment

Families with children involved in the juvenile justice system

Required documentation
Documentation that the youth is at-risk of, involved in or alleged to be involved in anti-social behavior. Documentation may be one of the following:

- the youth has been referred to juvenile court intake because he/she is either alleged or adjudicated delinquent under s. 48.12, Wis. Stats.
- the youth is an alleged or adjudicated child in need of protection or services (CHIPS) under s. 48.13(4), (6), (6m), (7), (9), or (12), Wis. Stats.

Typically, although not required, the referral will be made via one of two forms: Court Referral-Juvenile (Law Enforcement Referrals) or Court Referral-Juvenile (non-Law Enforcement Referrals).

Families where the primary care giver has a mental illness, developmental disability or substance abuse disorder

Required documentation
The caregiver has a diagnosis of a developmental disability, alcohol or other drug abuse or dependence, or mental illness. The diagnosis must be made by a qualified professional.

In addition to this diagnosis, the case management agency documents that as a result of the disability, the child's physical or emotional development or ability to engage in usual activities is restricted.

Families where the mother required prenatal care coordination services

Required documentation
Documentation needed for eligibility includes one of the following:

- evidence that the mother was involved in a Medicaid Prenatal Care Coordination (PNCC) program
- a completed Medicaid PNCC risk assessment showing that the mother was at risk for an adverse pregnancy outcome (even though the woman may not have participated in the PNCC program)

In addition, the provider must document that coordination activities continue to be required to ensure the best possible health outcome for the child.

Children enrolled in a Birth to 3 program certified under HSS 90, Wis. Admin. Code

Required documentation
The child has been found eligible to participate in the Birth to 3 program according to criteria found in HSS 90.08, Wis. Admin. Code.

Children with asthma

Children included in this category
This population consists of individuals under 21 years of age who have asthma.

Required documentation
Documentation needed for eligibility includes all of the following:

- a physician's diagnosis of asthma
- documentation that the severity of the asthma is moderate to severe, requiring active management to ensure the best possible clinical outcome

Individuals infected with tuberculosis

Recipients included in this category
There is no age limit on this group.

Required documentation
Documentation needed for eligibility includes *one* of the following:

- a positive TB skin test (if the skin test was done more than six months before the date case management was initiated, the provider must document that the recipient has not been treated or still requires treatment)
- a positive sputum culture for the TB organism within the past six months
- a physician's certification that the individual requires TB-related drug/or surgical therapy (even when the TB test is negative)
- a physician's order for testing to confirm the presence (or absence) of the TB organism
- a TB-related diagnosis by a physician

New Target Populations
Assessment and Case Planning Policy

This attachment describes assessment and case planning requirements that apply to the new target populations described in Attachment 1.

Wisconsin Medicaid covers two comprehensive assessments and two case plans per year

Wisconsin Medicaid covers up to two comprehensive case management assessments and two case plans per year for the new target populations listed in Attachment 1, even when they have not changed county of residence. The recipient's record must indicate the rationale for a new assessment. Wisconsin Medicaid does not cover more than two assessments and/or case plans per year, even if the recipient subsequently changes county of residence. All other target groups are limited to one assessment unless county of residence changes.

The comprehensive assessment is the assessment of all components described in HSS 107.32 (1) (b), Wis. Admin. Code. The time spent by all the individuals participating in that assessment is covered by Wisconsin Medicaid.

A review of the case plan or the recipient's status, when performed by the single designated case manager, should continue to be billed as ongoing monitoring and service coordination.

Families with a Child at Risk of Physical, Mental, or Emotional Dysfunction Additional Assessment and Case Planning Requirements

This attachment describes additional assessment and case planning requirements for the subgroup, families with a child at risk of physical, mental, or emotional dysfunction.

Assessment

In addition to completing the 15 assessment components described in HSS 107.32 (1) (b), Wis. Admin. Code, (found on page U2-001 of the case management handbook) for the identified child at risk, the assessment for families with a child at risk of physical, mental or emotional dysfunction must include the following components:

1. An assessment must be completed of the needs of any primary caregiver, where that person's condition (e.g., mental illness, substance abuse disorder, maltreatment) is the primary reason for the child being at risk and the caregiver is not already served by a case manager under Wisconsin Medicaid. The assessment must include those components of the comprehensive assessment which are applicable to the caregiver's situation.

2. An assessment must be completed of the needs of other child(ren) in the family when the conditions placing the identified child at risk might also place the other child(ren) at risk (e.g., maltreatment) and the other child(ren) are not already served by a case manager under Wisconsin Medicaid. The assessment must include only those components of the comprehensive assessment which are applicable to the other child(ren). Where components of the assessment apply equally to the identified at-risk child and other child(ren) in the family, these components must not be duplicated in the assessment of the other child(ren) in the family (e.g., needs of the primary caregiver).

3. An assessment must be completed of the family's functioning as a system as it impacts on the family's ability to provide for the needs of the identified at-risk child and other children in the family deemed to be at risk after further assessment. The following are *examples* of the types of factors that might be considered:

   ✓ *family communication*
   whether the family communication is open, clear and effective or interferes with healthy family functioning

   ✓ *family organization and structure*
   the family roles, whether appropriate boundaries exist between adults and children in the family, whether the family is cohesive or unstable, organized or chaotic

   ✓ *family relationships*
   whether relationships are satisfying, how emotions are expressed, and whether or not there is a history of violence

   ✓ *family decision-making*
   how the family solves problems and how effective this process is

   ✓ *family resources/support*
   how the family uses formal and informal community resources, what support is available to the family

   ✓ *family integration into the community*
   how isolated or involved the family is with the community

   ✓ *family demographics*
   how work, housing, child care or health

issues impact the family, how the family handles stress from these factors

4. Identify other case managers who are working with members of the family and their activities with the family.

Case plan

For family case management, the case plan should address the case plan components [found in HSS 107.32 (1) (c), Wis. Admin. Code, (and in the case management handbook, page U2-002)] as they apply to the assessment of the needs of the identified at-risk child, Medicaid-eligible caregivers and other Medicaid-eligible children in the family.

In addition, where multiple members of the family have case managers, the case plan will identify how the activities of the various case managers will be coordinated so that duplication of effort will not occur. This applies even if the services of the other case manager are not related to the specific conditions placing the identified child at risk or not. The family's preferences as to which case manager should provide which services must be taken into account when the roles of the case managers overlap.

Requirements for coverage of recipients prior to issue of this *Update*

Some case management services were provided to families with a child at risk of physical, mental and emotional dysfunction prior to the issue of this *Update.* These services are covered if all the assessment and case plan components identified in the case management provider handbook (Part U) at the time of assessment and case planning were completed.

However, providers must complete and document the additional requirements identified in this attachment by June 1, 1996, in order for coverage of case management to this target population to continue.

Attachment 4

Guide for Local Health Departments Providing Medicaid Case Management Services

This is a guide for local health departments providing case management services. This attachment highlights the differences between current local health department practice and case management requirements.

Assessments

Case management assessments must include the 15 components, as applicable, which are identified in HSS 107.32 (1) (b), Wis. Admin. Code, and in Section II of the case management handbook. If certain components are not applicable, e.g., no legal involvements, the provider should indicate this in the recipient's record.

Many of the required assessment components are covered in a standard public health nursing assessment such as:

- a review of the recipient's physical health
- performance in activities of daily living
- social skills and social relationships
- description of the physical environment
- need for adaptive equipment
- need for assistance with decision-making
- vocational or educational status

However, the public health case manager must be sure to also evaluate the recipient's need for housing, the presence of any psychiatric symptomatology, the financial resources available to the recipient, involvement with the legal system, and all other components.

Case plans

The case plan requirements are outlined in HSS 107.32 (1) (c), Wis. Admin. Code, and Section II of the case management handbook. Public health case managers must be sure to identify *all formal services* to be arranged for the recipient, not just those provided through the local health department. It is important to identify who will provide services in addition to the public health nurse and when these services will be initiated.

Ongoing monitoring and service coordination

Because public health case managers will be providing services to the recipient and family as well as conducting case management activities, *care must be taken not to bill services as case management.* Case management includes those activities required to help a recipient and the recipient's family gain access to, coordinate or monitor necessary medical, social, educational, vocational, and other services.

Activities *not* allowable as *case management* activities are:

- Provide counseling on good health practices, parenting, nutrition, and self care.
- Provide education to the recipient and family about disease, disease transmission and drug treatment.
- Administer TB tests or medication [including directly observed therapy (DOT)].
- Provide other direct health care services.

Activities allowable as case management activities include arranging for the recipient to receive any of the above services from another provider, as indicated in the case plan.

The following *are* allowable case management activities when included in the case plan.

- Monitor whether the services being provided according to the case plan are meeting the recipient's needs, and modify the plan, as needed. This may include direct observation of the recipient receiving services from other providers.
- Provide information and referral to community resources, as identified in the case plan.
- Provide client-specific advocacy necessary to assist the recipient and the family to gain access to services and resources identified on the case plan.
- Have face-to-face, phone, or written contacts with collaterals--including care providers, informal support persons, and others involved with the family--for the purpose of implementing the case plan and monitoring the recipient's response to services.
- Hold client-specific staffings and formal case supervision.

90 days to complete assessment and case plan for recipients with TB

Wisconsin Medicaid generally requires that the provider complete an assessment and case plan before billing ongoing monitoring and service coordination. However, because of the public health risk presented by recipients with TB, Wisconsin Medicaid will cover ongoing monitoring and service coordination for 90 days before completion of an assessment and case plan for recipients in the TB target population. The assessment must be completed as soon as possible, but not later than 90 days following the start of case management.

All Target Populations - All Age Groups
Assessment and Case Planning Policy

This attachment clarifies assessment and case planning policy for all target populations.

Eligibility determinations and case management assessments

Certain components of the comprehensive assessment may be completed as part of a determination that a recipient meets any target population eligibility criteria. The time for completing this may be billed as part of the case management assessment when the person is found to be eligible for case management. This policy does not apply to the three-person team determination that a child is severely emotionally disturbed.

Frequency of case plan reviews and monitoring

The case plan must be reviewed according to the time frames in the plan, but at least every six months. This review must include the case manager and the recipient and/or the parent or guardian and must be documented in the recipient's record. Other persons may be included as agreed upon by the case manager and recipient or parent/guardian.

Frequency of ongoing monitoring should be discussed and documented as part of the case planning process. This should include an indication of the frequency of contact with the recipient, the parent/guardian, and if applicable, with collaterals. Collaterals are other family, friends, providers, or anyone instrumental to the care plan.

The rationale for the frequency of monitoring must be explicitly noted in the recipient's record if the frequency of monitoring is less than a face-to-face recipient/family/guardian contact every three months and a face-to-face, telephone, or written recipient or collateral contact every month.

The rationale should be based on one or more of the following factors:

- the stability or frailty of the recipient's health
- the ability of the recipient or the family to direct the care
- the strength of supports in the home or the recipient's informal supports
- stability of, and satisfaction with, service care staff (e.g., is there a history of high staff turnover?)
- stability of care plan (e.g., is there a history of numerous changes?)

Billing for assessments

A number of individuals may be involved in completing the comprehensive case management assessment. Case management agencies may bill for the costs associated with any individuals involved in the assessment, as long as all of the following requirements are met:

- each individual meets the minimum requirements for a provider of case management assessment (see next sections)
- the case record documents the participation of each individual in the assessment
- the case management agency incurred a cost in providing the assessment

Some assessment activities may be covered under another Medicaid benefit. If this is the case, the activity must be billed to that benefit. For example, if a Medicaid-certified occupational therapist (OT) conducts an assessment of adult daily living which meets the Medicaid covered services requirements, the services may only be reimbursed as OT services, not as case management services.

Billing for case plans

A number of professionals may be involved in preparing the case plan. Case management agencies may bill for the costs associated with any professionals involved in the case planning, as long as all of the following requirements are met:

- the case record documents the participation of each professional in the case planning
- the case management agency incurred a cost in providing the case planning service

Case manager qualifications

Case manager qualifications

Wisconsin Medicaid requires that case managers reimbursed for assessment and case planning activities must meet one of the following qualifications:

- possess a degree in a human services-related field, possess knowledge regarding the service delivery system, the needs of the recipient group or groups serviced, the need for integrated services and the resources available or needing to be developed, and have acquired at least one year of supervised experience with the type of recipients with whom they will work
- possess two years of supervised experience with the type of recipients with whom they will work
- possess an equivalent combination of training and experience, as determined by the case management agency

Registered nurses as case managers

For the purpose of meeting the first requirement (possession of a degree in human services), a registered nurse with a bachelor's degree in nursing is considered to possess a degree in a human services-related field.

Determining a human services-related field

Policy:

The case management standards specifically delegate the determination of credentials to the certified case management agency.

> "The agency shall maintain a list of the individuals employed by or under contract to the agency who are performing case management services for which reimbursement may be claimed under MA. This list shall certify the credentials possessed by the named individuals which qualify them under the standards specified in sub. (2)."
>
> HSS 105.51(3), Wis. Adm. Code

Guidance:

The qualifications for a case manager providing assessment and case planning (noted above) do not define a human services-related field. We suggest that case management agencies review the individual's records to identify the amount of course work completed in areas that are relevant to case management, e.g., human development, long-term care, psychology.

Also, review the individual's training, experience, or a combination of training and experience to make a determination of equivalency to the standards.

All Target Populations
Case Management Assessments for Children and Adolescents

This attachment clarifies assessment policy when serving children and adolescents.

An assessment must be completed for all case management recipients

Wisconsin Medicaid identifies 15 components which must be evaluated as part of the comprehensive case management assessment (HSS 107.32 (1) (b), Wis. Admin. Code, and the case management handbook, page U2-001). Wisconsin Medicaid does not require use of a particular assessment tool, as long as the tool used includes the required components.

A completed assessment must be on file in the recipient's record for all recipients receiving Wisconsin Medicaid case management services. The assessment forms the basis for the case plan and the allowable case management services provided by the case manager.

Assess only those components applicable to the recipient

Some components of the comprehensive case management assessment may not be applicable to a particular individual.

The case manager needs to indicate that he or she has considered each component and determined when a particular component is not applicable. For example, individuals not involved with the legal system do not need to be assessed further for legal status.

Some components do not have to be further assessed in certain cases (i.e., where the physical environment is not an issue for the recipient's safety and mobility, if there are no issues around the need for housing, residential support, adaptive equipment, assistance with decision making.)

Guidance: assessment components should be interpreted in terms of children's needs

Case managers should make every effort to interpret the assessment components in terms of the child's needs. Educational needs, for instance, may include an infant's need for cognitive stimulation by the caregivers, even where "formal" education is not required. Where the safety of the physical environment may consist of handrails for the frail elderly, it may consist of outlet plugs for homes with toddlers.

A variety of assessment instruments for children evaluate the child's progress toward basic developmental milestones (Denver Developmental, WISRM) and measure all or some of the following areas:

- self care/adaptive activities
- receptive and expressive language/communication
- learning/cognitive development
- mobility/physical development
- self direction/social and emotional development

These assessments can partially or fully fulfill the requirements to review the child's performance in carrying out activities of daily living and social status and skills. In the absence of other psychiatric symptomatology which needs further professional evaluation, these assessments will also meet the requirement to evaluate the mental and emotional status.

All Target Populations
Court-related Service Coordination and Medicaid Case Management

This attachment clarifies when court-related services may be covered as Medicaid case management services.

Recipients become court involved in a variety of ways

Medicaid eligible recipients receiving case management services may become involved with the court system in a variety of ways:

- as a child in need of protective services
- as an individual who requires guardianship and protective services
- as an individual believed or found to require civil commitment to treatment services
- as an individual who has been accused of, or found guilty of, a criminal offense or a juvenile alleged or adjudicated delinquent for an act that would be a crime if committed by an adult

Covered court-related services

The actions of the court will have an impact on the services available to the recipient. The court may order the recipient to receive certain services. Wisconsin Medicaid covers case management activities related to the court system when they are necessary for one of the following reasons:

- advise the court on the service needs of the recipient
- coordinate the court orders with other requirements the recipient is obligated to meet
- assist the recipient to participate in the legal process and comply with the order of the court

Covered activities may include the preparation of reports to the court, communication (face-to-face, telephone or written) with court personnel, actual court appearances, and activities to ensure compliance with the court order.

Because reimbursable case management activities must be identified in the recipient's treatment plan, the case manager must revise the treatment plan, or indicate through notes in the recipient's record, the reason for the court involvement and the activities required by the case manager as a result of the court involvement.

Limitations on court-related services

Case management is not a covered service for individuals in hospitals or nursing homes, except for the 30 days prior to discharge from the facility. Therefore, none of these court-related activities (e.g., WATTS reviews) are covered when a recipient is in one of these facilities, unless they are discharged within 30 days of the date of the service.

Medicaid services are not covered on dates of service when the recipient is detained by the legal process. Therefore, none of these court-related services are covered on days when an adult is in jail, or a youth is in secure detention. Individuals who are in jail, but have Huber work release privileges, are not eligible for Medicaid services. Exception: Individuals who have Huber privileges to provide care to a family member in the home *are* eligible for Medicaid services.

The case manager ensures that the court is aware of the recipient's treatment needs and available resources. Wisconsin Medicaid does not cover case management activities when case managers may be acting in the capacity of legal counsel or attorney.

Case management examples

The following are examples of case management activities covered by Medicaid when provided to eligible recipients:

① Report on the findings of an assessment that meets the criteria for a comprehensive case management assessment. The assessment may have been done on a child believed to be in need of protective services or an individual believed to be in need of guardianship services. This reporting may be in the form of a written report to the court or as an actual court appearance.

② Participate in dispositional/commitment hearings, when the case manager is required to do one of the following:

- ✓ advise the court on the services required by, and/or available to, the recipient
- ✓ assist the recipient in understanding the court orders and participating in the dispositional process

③ Prepare periodic reports to the court, as required.

④ Provide activities necessary to recruit and retain a guardian or guardian ad litem for a recipient, when the court orders a guardian.

- ✓ The recruitment must be specific to recipients for whom the case manager is claiming reimbursement. If one or more case manager(s) meets with a group of potential guardians, or individuals who have agreed to be guardians, and there are two or more identified recipients for whom guardians are being recruited, the case manager(s) time should be equally divided and billed on behalf of the different recipients.
- ✓ Recruitment activities include:
  - preparing informational literature for a guardian
  - meetings with potential guardians, or individuals who have agreed to be guardians, to explain the roles and responsibilities of the position
  - providing ongoing assistance to the guardian so that the guardian can fulfill the responsibilities of the position. This may include educating the guardian on the service needs of the recipient, the service system in general, and the condition or conditions which have led to the recipient requiring guardianship. This also includes assisting the guardian in completing any required reports to the court.

⑤ Provide activities necessary to recruit and retain payees, when a payee is required by the Social Security Administration.

Allowable activities are those identified above for guardian recruitment and retention. Providing payee services directly to the recipient is not a covered case management service.

All Target Populations
Ongoing Monitoring and Service Coordination Policy

This attachment clarifies policy for covered ongoing monitoring and services coordination for all target populations.

Family case managers may not provide case management on behalf of family members who are not Medicaid-eligible

Case management interactions with a non-Medicaid eligible parent/guardian on behalf of an eligible child are allowable when all of the following are met:

- the case manager is assisting the parent/ guardian to gain access to services and resources which are required because of the child's condition
- the services or resources are ones to which the parent/guardian would not require access if the child did not have the condition that makes the child eligible for case management

The case manager may assist a non-Medicaid-eligible parent to locate and access the services that the child needs as identified in the case plan. They may also assist the non-Medicaid eligible parent access services the parent requires so they can best meet the child's needs - as in Examples A and B.

Example A
A Medicaid-eligible child is found to be eligible for case management because of cerebral palsy. The parent needs to find specialized transportation in order for the child, who uses a motorized wheelchair, to receive treatment services. Wisconsin Medicaid covers the case manager assisting the parent in locating an appropriate transportation provider even if the parent is not Medicaid eligible.

Example B
A Medicaid-eligible child is found to be eligible for case management because of cerebral palsy. The parent requires education to learn about the disability and how to best care for the child. Wisconsin Medicaid covers a case manager assisting the parent in accessing an education group.

Example C
A Medicaid-eligible child is found to be eligible for case management because of risk of abuse. The parent is found to require substance abuse treatment. Wisconsin Medicaid does not cover the case manager assisting a non-Medicaid-eligible parent to obtain substance abuse treatment even though it might indirectly reduce the risk to the child. The substance abuse treatment is meeting the parent's primary treatment needs.

When the other family member is Medicaid-eligible, Wisconsin Medicaid covers those activities identified on the family case plan aimed at the other family member's service needs, even if they are meeting the family member's primary treatment needs. In example C, the case manager's activities are covered by Wisconsin Medicaid if the caregiver is Medicaid-eligible and the activities are identified on the family case plan.

Transporting recipients

On occasion, case managers are expected to accompany recipients to services. The purpose is both to ensure that the service provider is aware of the overall case plan and to monitor the services the provider is delivering. If the case manager transports

the recipient on these occasions, this transportation time is covered under case management.

Split travel time when case management is not the only service provided

When a case manager travels to a recipient's home and provides both case management and other services, the travel time should be prorated so that only the appropriate portion of travel is claimed as case management.

Example
The case manager must travel one-half hour each way to a recipient's house and provide one-half hour of case management and one half-hour of assistance with personal tasks (which is not case management). Only half of the travel time (one-half hour) may be billed to case management.

Whether the remainder of the travel time can be billed to Wisconsin Medicaid depends upon whether the other service provided is covered by Wisconsin Medicaid and what the policies are for travel associated with that service.

Example
A provider travels one-half hour each way to a recipient's house. The provider provides one-half hour of case management and one and a half hours of in-home psychotherapy. Since travel time is billable with in-home psychotherapy, the provider should bill 15 minutes of the travel to case management and 45 minutes to in-home psychotherapy.

If the case manager travels to a location, such as a group home, where he or she sees more than one recipient, the case management time should be allocated on a pro-rated basis to the different recipients.

Example
The case manager must travel one-half hour each way to see two recipients at one site. One-half hour of travel should be billed on behalf of each recipient.

Wisconsin Medicaid does not cover travel time if there is no billable service

If a case manager travels to see a recipient or collateral, but does not actually make a contact (because the person was not home or available), Wisconsin Medicaid does not cover that travel time. Travel time is only covered when it is provided as a part of a covered service. Since no service took place, the travel time is not covered.

Reporting time

Ongoing monitoring and service coordination may be billed only one time per month.

On individual dates of service, providers may record their actual time (e.g., 3 minutes, 45 minutes) or accumulate the time spent on case management services on that day and round to the nearest one-tenth hour.

On a monthly basis, providers must add up the time for the individual dates of service. If actual time was recorded on individual dates of service, the accumulated time at the end of the month must be rounded to the nearest one-tenth hour. See Appendix 7 of the case management (Part U) handbook for rounding guidelines.

Example
A case manager has billable contacts on three days during a month: a 1 hr. and 15 minute meeting with a recipient (including travel and recording time), a 10 min. phone call with a collateral and another 20 min. phone call with a collateral. If the case manager records actual time, these are accumulated at the end of the month to 1 hr. and 45 minutes and billed to Medicaid as 1.8 units of services. If these are rounded on individual days (to 1.3 units, .2 units, and .4 units) they are accumulated at the end of the month and billed to Medicaid as 1.9 units of services.

Information and referral is case management

Wisconsin Medicaid considers information and referral a covered case management service. Information and referral means providing recipients with information about resources and programs available to the recipient as part of the process of helping the recipient to gain access to services.

Case managers who are also service providers

Wisconsin Medicaid does not prohibit providers of other services (whether Medicaid covered or not) from being case managers. For instance, staff of a day treatment program or a sheltered workshop may be case managers. However, the case manager must not bill services which are associated with their role as a service provider as Medicaid case management.

Example
A provider of in-home treatment for a child with severe emotional disturbance is also providing case management. As the child's case manager, the provider completes the comprehensive case management assessment and also convenes an interagency team to complete the case plan. These activities are covered under case management. One of the services identified on the case plan is the in-home treatment. The in-home team develops a treatment plan for the in-home services. Development of this treatment plan is *not* covered under case management.

Similarly, documentation of the in-home treatment is considered a part of that service and is not covered as case management. Only documentation of the case management activities in support of the case management case plan are covered as case management documentation time.

If case management is a component of the other services which the provider is providing and included in the Wisconsin Medicaid payment for that service, it may not be separately billed under case management.

Ongoing review of the case plan by the single designated case manager is part of the ongoing monitoring and service coordination

The comprehensive assessment may only be reimbursed by Wisconsin Medicaid once per calendar year *for existing target populations* unless the recipient changes county of residence. However, the single, designated case manager is expected to review the appropriateness of the case plan on an ongoing basis and make changes, as needed. This activity may be billed as ongoing monitoring and service coordination and, as such, can be included in the monthly billings.

Recipients should be notified of a reduction or termination of services

Changes in the case plan should always be discussed with the recipient/guardian/parent. A decision that services can be reduced or terminated should be mutually agreed upon. If the case management agency needs to reduce or terminate services for any reason, the case manager should notify the recipient in advance and document this in the record.

Case specific staffings and meetings with unit supervisors are collateral contacts

HSS 107.32 (1) (d), Wis. Admin. Code, defines collateral contacts to include case specific staffings and meetings with unit supervisors in which the recipient's issues are discussed. Therefore, these activities may be reimbursed under case management even if no other collateral or recipient contacts occurred during the month. Staffing or clinical supervision time which is not client-specific is not a covered case management service.

Potential for Duplication of Services
All Target Populations

This attachment explains how providers can avoid duplicate billing for Medicaid services.

Medicaid case management services

Family case managers must bill their services using the Medicaid identification number of the identified at-risk child

Although a family case manager will address the needs of the family as a whole, case management must be billed under the Medicaid identification number of the at-risk child.

Wisconsin Medicaid does not cover more than one family case manager per family

It is possible that more than one Medicaid-eligible child in a family can be considered at risk and, therefore, eligible for family case management. Because the family case manager is responsible for assessing and addressing the needs of other Medicaid-eligible children in the family, and the family's needs, Wisconsin Medicaid does not cover more than one family case manager per family. Providers serving the family at the local level are expected to communicate with each other and with the family to determine which agency will provide the family case management.

Wisconsin Medicaid will cover both the services of the family case manager and the services of other case managers serving members of the family, only when the care plan identifies how their activities will be coordinated so as not to be duplicative

A family may have a child at risk of physical, mental or emotional dysfunction at the same time that another family member is part of another eligible case management target population. This is highly likely in cases where it is the parent's condition which puts the child at risk, as with a parent with a mental illness or developmental disability. Because of the different knowledge required by each case manager, Wisconsin Medicaid finds that it is appropriate that both case managers remain involved with the individuals and family.

However, Wisconsin Medicaid will cover both a family case manager and other case managers working with members of the family only if there is documentation that their activities have been coordinated through the case planning process so as not to be duplicative.

Wisconsin Medicaid does not cover more than one case manager per individual recipient

A given child may be eligible for case management under more than one target population, e.g., as a child at risk and as a child with developmental disabilities. The child's needs may bring that child into contact with multiple agencies eligible to

provide case management, e.g., the Birth to 3 program and the local health department. However, Wisconsin Medicaid will cover only one case manager for that individual child. Providers at the local level are expected to communicate with each other and the family to determine which agency will bill Medicaid for case management activities.

HealthCheck outreach and case management services

Wisconsin Medicaid sometimes uses the term "case management" to refer to the case management provided to certain populations as described in HSS 107.32, Wis. Adm. Code, and in the case management (Part U) handbook. Wisconsin Medicaid also reimburses certain agencies to ensure that HealthCheck eligible recipients (individuals under 21 years of age) receive their HealthCheck screens according to the periodicity schedule and obtain referrals to services recommended as a result of the screen. This is referred to as "HealthCheck case management." If the same agency is providing HealthCheck outreach and Medicaid case management to a recipient, the service must be billed as targeted case management, since ensuring access to HealthCheck screens and related necessary services is a component of targeted case management.

If HealthCheck outreach is provided by an agency different from the agency providing Medicaid case management, Wisconsin Medicaid will cover services by both agencies only if their activities are not duplicative. The targeted case manager must ensure that the activities are coordinated. The purpose of HealthCheck outreach is to get the child screened and make referrals based on the screening. Targeted case management coordinates a broader array of services identified in the child's case plan.

Medicaid case management and prenatal care coordination (PNCC)

Women who are pregnant with a high risk of an adverse birth outcome are eligible for Medicaid PNCC services. The PNCC agency is responsible for ensuring that the woman gets necessary prenatal care and also addressing other issues which might put the woman at risk (e.g., substance abuse, domestic abuse).

Wisconsin Medicaid will reimburse both the PNCC agency and the targeted case management agency for providing services to the same recipient at the same time as long as the services are not duplicative. Because PNCC is time limited (to 60 days after the birth), the targeted case manager should take responsibility for coordinating the efforts of the two agencies so as to avoid duplication of effort. The targeted case manager and the PNCC case manager should decide, along with the recipient, which agency will provide which services.

An example:

A woman with a significant history of substance abuse is admitted to a PNCC program because of the risk of an adverse birth outcome. The woman has a Medicaid case manager because of her substance abuse disorder. The "targeted" case manager has been working with the woman to help her find treatment and is also working on housing and nutrition needs.

After the woman's admission to the PNCC program, the targeted case manager revises the woman's case plan to identify her involvement with PNCC and the need to coordinate efforts with the PNCC agency. The targeted case manager meets with the PNCC staff and discusses their responsibilities with the recipient. The targeted case manager will continue to work with the recipient on accessing substance abuse treatment and on housing issues. The PNCC agency will work on accessing prenatal care, educating the recipient on perinatal health issues and addressing nutrition needs. Each agency's role is written in each care plan.

Medicaid case management and children in child welfare

County staff may not be reimbursed for case management services to children and families in the public child welfare system. This is because the State of Wisconsin already claims federal reimbursement for these services under the federal foster care funding (Title IV-E).

However, there are four circumstances in which county staff could be reimbursed for case management services to children and families:

1. court attached juvenile workers
2. Department of Community Programs staff
3. Department of Development Disabilities Services staff
4. Department of Human Services staff for public health, mental health, substance abuse or developmental disabilities services

In addition, private agencies under contract with the county can be reimbursed for case management to children and families in the public child welfare system.

An example:

A county that operates an outpatient mental health clinic may be reimbursed for staff from these clinics when they are providing covered case management services.

Guidelines For the Coordination of Services Between HMOs and Case Management Agencies

The purpose of the attachment is to identify the roles and responsibilities of HMOs and case management agencies when they are working with common recipients. This same language will be incorporated as both an Addendum to the HMO contract and an Appendix in the case management provider handbook, ensuring that both HMOs and case management providers have the same language available to them.

HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case Management providers. If the HMO chooses to designate more than one contact person, the HMO should identify the target populations for which each contact person is responsible.

2. The HMO may make referrals to case management agencies when they identify a recipient from an eligible target population who they believe could benefit from case management services.

3. If the recipient or case manager requests the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment. If the HMO finds that assessment is needed, the HMO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO will document the rationale for this decision.

4. The HMO must determine the need for medical treatment of those service covered under the HMO contract based on the results of the assessment and the medical necessity of the treatment recommended.

5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required.

- The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting.

- The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the recipient or case manager.

- The HMO case management liaison and the case manager must discuss who will be responsible for ensuring that the recipient receives the services authorized by and provided through the HMO.

- The HMO's role in the case planning may be limited to a confirmation of the services the HMO will authorize if the recipient and case manager find these acceptable.

Case Management Agency Rights and Responsibilities

1. The case management agency is responsible for initiating contact with the HMO to coordinate services to recipient(s) they have in common and provide the HMO with the name and phone number of the case Manager(s).

2. If the HMO refers a recipient to the case management agency, the case management agency must conduct an initial screening based on their usual procedures and policies. The case management agency must determine whether or not they will provide case management services and notify the HMO of this decision.

3. The case management agency must complete a comprehensive assessment of the recipient's needs in accordance with the requirements in the Part U provider handbook. This includes a review of the recipient's physical and dental health needs.

4. If the case management agency requires copies of the recipient's medical records, the case Management agency must obtain the records directly from the service provider, not from the HMO.

5. The case manager must identify whether the recipient has additional service or treatment needs. As a part of this process, the case manager and the recipient may seek additional assessment of conditions which the HMO may be expected to treat under the terms of its contract, if the HMO determines there are specific signs and symptoms indicating the need for an assessment.

6. The case management agency may not determine the need for specific medical care covered under the HMO contract, nor may the case management agency make referrals directly to specific providers of medical care covered through the HMO.

7. The case manager must complete a comprehensive case plan in accordance with the requirements of the Part U provider handbook. The plan must include the medical services the recipient requires as determined by the HMO.

8. If the case management agency specifically requests the HMO liaison to attend a planning meeting in person, the case management agency must reimburse the HMO for the costs associated with attending the planning meeting. These are allowable costs for case management reimbursement through Wisconsin Medicaid.

Nothing in these guidelines precludes the HMO and the case management agency from entering into a formal contract or Memorandum of Understanding to address issues not outlined here.

Important . . . . . .

Wisconsin Medicaid Provider Handbooks are designed so they can be updated easily. Only the handbook pages which have changed are sent to you. The entire handbook is not reissued to you so that we save natural resources.

What to do with these replacement pages?

☞ Follow these easy instructions:

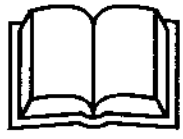
① Don't throw away the entire handbook!

② Use the enclosed filing instructions which show the pages to remove from your current handbook. **Remove** the pages indicated (don't forget to recycle the paper)!

③ Now, refer to the filing instructions to insert the revised pages you received from Wisconsin Medicaid.

Your handbook is now updated with the most current information on Wisconsin Medicaid.

Replacement Pages



Wisconsin Medicaid
Provider Handbook

Filing Instructions for Part U Replacement Pages

Remove these pages...	Insert these pages...
Transmittal Log dated 12/93	Transmittal Log dated 06/96
Section V: Page U5-009 dated 11/92 Page U5-011 dated 11/92	**Section V:** Pages U5-009 and U5-010 dated 06/96 Page U5-011 dated 06/96

PART U
CASE MANAGEMENT PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Providers must delete old pages and insert new pages as instructed. Use of this log will eliminate errors and ensure an up-to-date handbook.

Each update to Part U of the handbook will be numbered sequentially. This sequential numbering system alerts the provider to any updates not received. For example, if the last transmittal number on your log is U-3 and you receive U-5, you are missing U-4. If a provider is missing a transmittal, copies of *complete* provider handbooks may be purchased by writing to the address in Appendix 36 of Part A, the all-provider handbook.

Transmittal Number	Initials	Issue Date
U-1		02/01/90
U-2		12/10/91
U-3		03/92
U-4		11/92
U-5		12/93
U-6		06/96

Transmittal Number	Initials	Issue Date

Appendix 3
Target Population Codes and HCPCS Procedure Codes for Case Management Services

Target Population Codes

Providers of case management services are required to indicate one of the following target population codes in element 21 of the National HCFA 1500 claim form. In all cases, target population codes ending in the letter B are intended to identify recipients who are receiving funding for any portion of their case management services through Community Options Program (COP).

Code	Description
01A	Developmentally Disabled
01B	Developmentally Disabled, COP
03A	Birth to 3
03B	Birth to 3, COP
18A	Alcohol and Other Drug Abuse
18B	Alcohol and Other Drug Abuse, COP
31A	Chronically Mentally Ill
31B	Chronically Mentally Ill, COP
36A	Alzheimer's Disease or Related Dementia
36B	Alzheimer's Disease or Related Dementia, COP
44A	TB
44B	TB, COP
57A	Physically or Sensory Disabled
57B	Physically or Sensory Disabled, COP
58A	Age 65 or over
58B	Age 65 or over, COP
64A	Under Age 21 and Severely Emotionally Disturbed
64B	Under Age 21 and Severely Emotionally Disturbed, COP
72A	Asthma
72B	Asthma, COP
88A	Families with child at risk
88B	Families with child at risk, COP
92A	HIV
92B	HIV-COP

HCPCS Procedure Codes

Procedure Code	Description
W7051	Assessment
W7061	Case Planning
W7071	Ongoing Monitoring and Service Coordination
W7062	Institutional Discharge Planning

Appendix 4
Case Management Target Population "Change Request" Form

Please send this form to:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Please note that you may add target populations at any time. All target population additions are effective when received unless a future effective date is specified. You may also subtract target populations at any time. All target population subtractions are effective when received.

NAME: _____ TITLE: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

COUNTY: _____

By signing this form, I am indicating to the Bureau of Health Care Financing the approval of this change by my County Board of Supervisors or Indian Tribal Government as required under s.49.45(25), Stat.

Indicate Populations You Will Be

	ADDING	OR SUBTRACTING
Persons who are Age 65 or Older	( )	( )
Persons Who Have a Diagnosis of Alzheimer's Disease or Related Dementias	( )	( )
Physically or Sensory Disabled	( )	( )
Developmentally Disabled Persons	( )	( )
Chronically Mentally Ill Persons	( )	( )
Alcoholic and/or Drug Abusing Persons	( )	( )
Severely Emotionally Disturbed Persons Under the Age of 21	( )	( )
Persons Diagnosed as Having HIV Infection	( )	( )
Families With Child at Risk	( )	( )
Birth to 3	( )	( )
Children with Asthma	( )	( )
TB	( )	( )

If ADDING a population, complete one of the following:

1. EFFECTIVE UPON RECEIPT? Y N

or

2. EFFECTIVE ON: _____
(Specify date)